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Stigma and Sexual Offenders: The Effect of Mental Illness on Attitudes and Social Distance

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**Abstract:**

Stigma affects certain groups within society and results in the discrimination and social exclusion of an individual based on their association with a stigmatized group. This can internally damage the individual and restrict them from basic life opportunities, severely impairing quality of life. Mental illness and offending are both attributes which are stigmatized by the public and can be related; both have increased difficulty re-integrating into society due to stigma. This is a problem for sex offenders, a particular group which elicit severe negative attitudes from the public. This study measured, for the first time, responses towards different types of sex offenders (child sexual abuse, rape, and a control group of violent offender), and whether a diagnosis of schizophrenia impacted these responses. 223 participants completed an online survey measuring punitive attitudes and social distance in response to a vignette. It was hypothesised that the child sex offender would receive the most punitive attitudes and desired social distance. Also, mental illness would sympathise attitudes but increase social distance for the child sex offender. Results showed, as predicted, the child sex offender elicited the most negative attitudes and greatest desired social distance, followed by the rapist then the violent offender. Mental illness only effected responses to social distance, specifically for the child sex offender; having a diagnosis of schizophrenia reduced the amount of social distance desired. This suggests that sex offenders are viewed more punitively than non-sexual offenders, that different types of sex offence are viewed differently, and close proximity with such an offender is not desired. Mental illness neither decreased nor increased negativity for this group, and reduced the desire for social distance for child sex offenders, which has positive implications for forensic psychiatric patients. Implications and future directions for public policy and the re-integration of sex offenders are discussed.

<b>Key Words:</b>	Stigma	Sexual Offender	Schizophrenia	Attitudes	Social Distance
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**Introduction:**

Stigma and discrimination is a long-lasting problem which affects many groups within society and significantly impairs their quality of life. This is no less the case for offenders and those who want to become re-integrated into society after committing crimes. A recent study by Nee and Witt (2013) has shown that awareness of mental health problems may reduce discriminatory attitudes towards offenders, despite mental illness being an attribute that has been found to be repeatedly stigmatized (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). Therefore, it could be beneficial to explore this finding in relation to groups of offenders who suffer extreme stigma and who also suffer from a mental illness. This may help us reduce the discriminatory attitudes which are detrimental to re-integrating offenders into society. However, there is very little empirical research about how the public feel towards offenders with mental illness, especially sex offenders, a group which elicit extensive public stigma (Brown, 1999). The present study seeks to address this issue by looking at whether the awareness of a mental illness impacts the public's perception of sex offenders. To that end, this introduction will review relevant literature and research on the formation of stigma, the stigma of mental illness, and the limited amount we know about the stigma associated with offending behaviour, before describing the aims of the current study.

**Stigma**

To understand the social construct of the world we live in, we naturally make assumptions about those around us, using our cognitive schemas to quickly collate information and make a judgment about a person or a group of people without requiring special attention (Goffman, 1963; Hamilton & Sherman, 1996). An important part of this process is placing people into various social groups based on shared characteristics; known as social categorisation. This process is a useful cognitive shortcut as it allows us to anticipate expectations from social situations (Bond & Brockett, 1987, cited by Smith, Mackie &

Claypool, 2014, p.144) and is based on threat or reward. In addition, it enables the world to be divided up into groups we perceive to share similar characteristics to us, known as the in-groups, and those who we perceive to be different, known as the out-groups. We tend to make the assumption that all members of an out-group are the same rather than a collection of individuals. This is where a foundation for stereotyping is formed; a mental representation of an individual based on their association to a social group (Smith, Mackie & Claypool, 2014). When stereotypes are held about groups that are perceived to involve negative traits and behaviour, they imply that all group members encompass the stereotype; if a person chooses to endorse the belief it can affect their feelings and behaviour towards members of that group, escalating to prejudice and discriminatory behaviour due to their emotional reaction to the stereotype (Corrigan & Walton, 2009). Groups who are widely stereotyped, negatively evaluated by society, and receive significant discrimination because of their association to that group, are at risk of becoming stigmatized; a concept which has been repeatedly shown to have a detrimental impact on life opportunities, well-being, and self-identity (Major & O'Brien, 2005).

Stigma has been a well-established social construct for over half a decade, derived by Goffman (1963) as “an attribute that is deeply discrediting” (p.3) and further by Crocker, Major and Steele (1998) as a “characteristic that conveys a social identity that is de-valued in a particular social context” (p.505). Whilst Goffman’s (1963) definitions have been fundamental in the development of stigma as a concept, since then there have been varying definitions and theories of stigma from several different fields and approaches. Link and Phelan (2001) criticised this, noting that variance in theoretical stances produced numerous attempts to conceptualize stigma with differing outcomes and little consistent research. They then proposed a conceptualization of stigma which includes elements from previous theory and definitions, including the social cognitive approach to understanding stereotypes and social categorisation previously noted in this article. They suggested that when labelling, stereotyping, separating ‘us’ and ‘them’, status loss, and discrimination occur in conjunction with a situation of power, a

groundwork for stigma is created. In other words, the individual begins to internalise the negative attitudes and behaviour towards them, resulting in this loss of status and a diminished self-identity. Empirical testing lends support to these elements in creating stigma, particularly for those with mental illness, a group which are extensively stigmatized (Estroff, 1989; Link, 1987). This article looks at how people perceive this group, in particular when they are associated with offending, an attribute which in isolation from mental illness is also subject to stigma (Hirschfield & Piquero, 2010; Nee & Witt, 2013).

Whilst Link and Phelan's (2001) conceptualization is of sound basis, it could be said that empirically testing all of these components occurring together as causal elements of stigma experimentally may be difficult. Corrigan and Watson (2002) proposed a social psychological model of public stigma towards people with mental illness. They based this model on research on the endorsement of negative stereotypes to determine prejudicial attitudes and in turn discriminatory behaviour, which is reflective of the believed stereotype. As important as identifying the concepts which contribute to stigma, is understanding the psychological effects of stigma for those stigmatized. They explained how the presence of activated stereotypes, prejudice and discrimination can cause self-stigma. This refers to the stigmatized also being aware of the stereotypes surrounding their group, which if endorsed and applied to themselves may deteriorate self-esteem and cause them to undermine their own capability (Corrigan & Walton, 2009; Corrigan & Watson, 2002). Major and O'Brien (2005) also proposed that they may appraise directed stigma to be harmful to their self-identity which they feel is outside of their ability to cope, creating low self-esteem, decrease in health and stereotype-threat. As a result, they may actively avoid interaction with others, especially outside their social group.

Therefore, the repercussions of stigma are clearly a detrimental issue to those on the receiving end and could affect their ability to function within society, build relationships and have fair employment opportunities. Attempting to tackle and improve this issue is of great importance for bettering the quality of life for those who are victims of stigma. This review now turns to the literature specifically on the stigma associated with mental illness.

## Stigma and mental illness

Identifying a person as 'mentally ill' comes with more consequences than simply understanding and placing people in a social group. Dating back to the Middle Ages, people who suffered mental illness were often referred to as 'mental patients' and 'insane', with asylums created not for their treatment but to "incarcerate and isolate the deranged" (Millon, 2004, p.5). These may be at the very extreme end of discriminatory behaviour towards people with mental illness, however it is surprising that evidence of these beliefs still prevails centuries later, despite statistics showing that 1 in 4 people experience some sort of mental illness (Time To Change, 2017). It is therefore of much interest and importance to be able to measure the public's attitudes and beliefs towards people with mental illness.

Based on Star's (1955) research into the public perception of mental illness, Link et al. (1999) measured a sample of 1444 on their perceptions of a range of psychiatric disorders by creating vignettes. They measured perceptions of causes, dangerousness, social distance and public recognition, and in comparing their findings to Star's (1955) they identified an increase in the public's recognition of what constitutes as a mental illness and their perceptions of causes. However, this positive increase was not consistent for their measurement of perceived dangerousness, which had in-fact increased. This correlated with the degree of desired social distance, implying that the more dangerous they are believed to be, the more they would like reduced contact with the individual. As these studies were administered to a US population, it cannot be assumed that these beliefs are not culturally specific. Nonetheless, a review of population studies on attitudes towards mental illness 1990 – 2004 across Europe and the US found that even though Westernised cultures are shown to be more knowledgeable about mental illness and the causes, there is consistent cross-cultural similarity in the perceived dangerousness and unpredictability of people with mental illness (Angermeyer & Dietrich, 2006). In addition, schizophrenia and alcoholism were considered more dangerous and unpredictable than those with anxiety or depression. This suggests that even though there may be negative connotations with being labelled as 'mentally ill', the nature of this may differ

due to the type of mental illness they are presented with. Similar results were found in Feldman and Crandall's (2007) study which measured 40 different types of mental illness. However, the sample was 270 first year psychology undergraduates and therefore it could be said to lack generalisability. Despite much research indicating that personal experience of mental illness reduces the desire for social distance and endorsement of negative stereotypes (Angermeyer, Matschinger, & Corrigan, 2004; Corrigan et al., 2001), this is not the case for knowledge of the biological causes. A recent systematic review (Schomerus et al., 2012) showed that advances in the understanding of the biological causes of mental illness did not correlate with increased acceptance. This could suggest that increased knowledge about the biological aetiology of mental illness causes people to blame the individual less, but knowing they cannot change or control their behaviour may cause them to fear them and consequently desire social distance. Consistent results have been found in surveys in the United States (Pescosolido et al., 2010) indicating that social distance is still an obstacle despite society having more familiarity and knowledge about mental illness. It would be useful to know whether knowledge of mental illness in different types of sexual offender would reduce or increase the desire for social distance.

It seems apparent that the existing literature supports the notion that mental illness, in particular psychotic disorders such as schizophrenia, is seen by society as feared and potentially dangerous to others. The present study looks at the impact of schizophrenia when coupled with an offence, to understand how the public respond to two attributes which have been shown to elicit stigma. Research does show evidence of an association between mental illness and violent behaviour, a potential explanation as to why this stereotype exists in society. The next section will review literature on the extent of the relationship between mental illness and crime, and how this may impact on the public's attitudes towards offenders with mental illness.



## **Offenders with mental illness**

Very little research has been done on the public's attitudes towards offenders with mental illness. An attempt to establish the link between having a mental illness and the propensity to violent crime has been extensively researched, yet has produced varying findings. Comparing population samples of mental illness and the general population and their rates of violent behaviour have in-fact shown a four-fold increase in reported violent behaviour for samples of mental illness (Swanson, Holzer, Ganju, & Jono, 1990). Whilst this research and direct comparison is useful, it does not put into perspective to what extent having a mental illness plays a part in violent criminal behaviour. Advances in recent methodology have used data from these studies and looked at the probability of violence due to mental illness in comparison to other potential risk factors for violence, to help establish the size of the problem. This has shown that whilst mental illness does have an association with violent crime, there are in-fact other factors such as age and gender which are more accurate at predicting potential dangerousness (Corrigan & Walton, 2009; Fazel & Grann, 2006). Based on this it could be said that perhaps the stereotypical beliefs about mental illness and dangerousness exaggerate the relationship between mental illness and violent crime. Therefore, it seems important to understand how the public perceives offenders who have a mental illness, as those offenders who have a mental illness may receive a double-stigma and discrimination from society which may be extremely detrimental to their rehabilitation and re-integration into the community; a problem for many ex-offenders identified by Hirschfield and Piquero (2010).

One of the few studies which investigates this area is Nee and Witt (2013), which measured public attitudes towards a person with a mental illness and a past conviction using vignettes. As well as measuring public attitudes on sympathy, trustworthiness, and rehabilitation, they looked at whether the presence of a mental illness alongside a criminal conviction would cause participants to feel the person would commit a serious crime in the future. This added an interesting dimension to the common attitudinal research, as it measured how a person expects and anticipates a person to behave in the future, a key component in how the public form stigma. Socio-economic status

was also manipulated, which in-fact showed that the most punitive responses and perceived likelihood of future criminal behaviour were towards a person with a past criminal conviction and a disadvantaged background, but with no mental illness. Contrary to research on public attitudes towards mental illness, schizophrenia received less negative responses, followed by depressive and anxiety disorders (Angermeyer & Dietrich, 2006). This has positive implications for stigma and mental illness, suggesting that the public are less stigmatizing towards an offender when it is apparent they have a mental illness, perhaps because they feel like they are less responsible and to blame. Based on this study we predict that offenders with mental illness will receive less harsh attitudes from the general public than those without.

### **Attitudes towards sex offenders**

Literature on attitudes towards offenders shows we hold contradictory views towards offenders and their rehabilitation, believing they should be incarcerated away from the public yet showing favourable attitudes towards rehabilitation (Reynolds, Craig & Boer, 2009). However, closer research shows different offences elicit variations in punitive attitudes (McCorckle, 1993). Sex offenders are a group which have been shown to receive persistent negative attitudes and discrimination from the public (Willis, Levenson & Ward, 2010), the latter having a significant role to play in how well offenders can re-integrate into society after being in prison and begin to re-build their lives (Tewksbury, 2011). Brown (1999) conducted a British survey on attitudes towards sex offenders receiving treatment and found that whilst people were supportive of them going through treatment, they were only supportive if the treatment was in a prison setting rather than in the community. The idea of sex offenders being released back into the community was also less favoured. The supportive attitudes towards rehabilitation contrasting with the desire for social distance can be explained by the 'not in my back yard' phenomenon (NIMBY) proposed by Benzvy-Miller (1990). This consists of a combination of stereotypical beliefs about the offender, fear that

being closer to that offender increases risk of being a victim, and the tarnish it would bring to their neighbourhood.

Few studies measure attitudes towards sex offenders without considering them as a homogenous group, however Kernsmith, Craun, and Foster (2009) measured levels of fear for different types of sex offences. Whilst most participants expressed fear at the idea of living near a sex offender, child sexual offences (paedophilia and incest) elicited the greatest levels of fear, and spousal or statutory rape provoked the least. These findings also support the NIMBY phenomenon that close proximity elicits fear, and supports the notion that desired social distance would be high for child sexual offenders. An inmate's description of the prison hierarchy states that sex offenders are "lowest on the list [...] Offences against children are the worst" and are subject to being "slashed" or scalded with hot water; this shows that even other offenders share the same attitudes as the public towards sex offenders, with child molestation considered the worst type of offence (Smith, 1995).

This kind of discrimination withholds employment opportunities for sex offenders; however, employment has been found to be a key factor in reducing re-offending (Craig, Browne, Stringer & Beech, 2005; Metcalf, Anderson & Rolfe, 2001). Tewksbury (2011) sought to understand the effect stigmatization has on sex offenders by conducting qualitative interviews with 24 sex offenders in prison. He found that sex offenders were well aware of the negative reaction towards them from both society and the general prison population; they internalise this feeling leading to reduced self-esteem and feelings of hopelessness, shame and fear of their identity, supporting the self-stigma concept proposed by Corrigan and Watson (2002).

Mental disorders such as anxiety, disorganized attachment, impulsive control and substance use have been consistently associated with sexual deviant behaviour, therefore there is evidence to suggest that many sexual offenders may also have a mental health problem (Burk & Burkhart, 2003; Harsch et al., 2006; Leue, Borchard, & Hoyer, 2004). Nevertheless, there is no research concerning the public's perception of sex offenders suffering from a mental illness.

The present study investigated whether serious mental illness would impact on the public's attitudes towards offenders, in particular their attitudes towards sex offenders. An independent subjects, web-based survey using vignettes measured attitudes to three types of offender as this method has previously shown to successfully gauge stigma and discriminatory attitudes in the public due to its anonymity (Link et al., 1999; Nee & Witt, 2013). The vignettes depicted two types of sex offender: a rapist and a child sexual offender, plus a violent offender. This sought to identify whether there would be differences in response between the two types of sex offence, using a violent offender as a control (who had nonetheless committed a very serious offence albeit not sexual in nature). A diagnosis of schizophrenia was either present or not present in the vignette. The survey measured attitudes towards offenders and social distance towards the vignettes. Based on existing research, it was predicted that the child sexual offender would elicit more punitive attitudes and a greater desire for social distance than the rapist who would in turn elicit more negative attitudes than the violent offender. It was predicted that when a mental illness was present, attitudes towards offenders would be more sympathetic. However, based on the 'not in my back yard' phenomenon it was predicted that for the child sexual offender social distance would be significantly higher when there was a mental illness present compared to the rapist and the violent offender.

**Method:****Table 1****Description of six vignette conditions**

<b>Vignette 1</b>	<b>Vignette 2</b>	<b>Vignette 3</b>	<b>Vignette 4</b>	<b>Vignette 5</b>	<b>Vignette 6</b>
Rape conviction, schizophrenia present	Child sexual abuse conviction, schizophrenia present	GBH conviction, schizophrenia present	Rape conviction, no schizophrenia	Child sexual abuse conviction, no schizophrenia	GBH conviction, no schizophrenia

**Design**

A 2 (mental illness/no mental illness) x 3 (type of crime: CSA/rape/GBH) independent groups design was used in this study which consisted of six experimental conditions, each condition containing a different written vignette. The first independent variable was the type of crime that participants were exposed to. This was manipulated in the vignettes, presenting them with either an offender convicted of rape, child sexual abuse (CSA), or grievous bodily harm (GBH). GBH was chosen as the crime for the control condition as it represented a similarly serious, interpersonal crime, but was not sexual in nature. As the aim of this study was to investigate whether a mental illness would elicit different responses than no mental illness, the second independent variable was whether there was a presence of a mental illness in the vignettes. As shown in Table 1, three out of the six vignettes contained a diagnosis of schizophrenia coupled with a conviction of one of the three types of offences. The dependent variables were participants' attitudes towards the offenders in the different vignettes and their desire for social distance from them.

## Participants

The study was advertised on social networking sites and participants were asked to email the researcher if they had an interest in taking part.

Participants were randomly assigned to each condition automatically by using a randomizer tool on the online survey system 'Qualtrics', which gave an equal spread of participants to each condition. Overall there were 241 participants in the study, although 17 were discounted due to incomplete responses. The age brackets were 18-25 years ( $n=137$ ), 26-40 years ( $n=36$ ), 41-60 years ( $n=45$ ) and 61 years and over ( $n=21$ ) and their occupations included students ( $n=63$ ), teachers ( $n=19$ ) and administrators ( $n=13$ ). A large age range and spread of occupations enabled the sample to be as generalisable as possible to the views of the public. Levene's tests indicated equal variance of participant characteristics across each condition.

## Materials

Survey software 'Qualtrics' was used to create the study online. Each vignette consisted of a brief A4 page description (word count ranged from 196-309) of a man called James based on a court report. The vignettes with the higher word count contained the diagnosis of schizophrenia (see Appendix 2). All vignettes contained the exact same background information; the only parts manipulated were the type of offence 'James' was convicted of, and whether or not he had a diagnosis of schizophrenia. The background information was kept as neutral as possible, as socio-economic status was not something that was being manipulated given the time and resource constraints of this project. Socio-economic background is a factor found to affect people's attitudes towards offenders with mental illness (Nee & Witt, 2013). Demographic information, details of his level of education and employment and mention of social activities were included in the description of 'James'. A brief sentence on the offence details was given describing the type of offence 'James' was sentenced to, the length of his sentence and where he was imprisoned; this sentence was introduced at the beginning of the vignette. At the end of the vignette a short sentence about the treatment programme which 'James' will

complete whilst in prison was mentioned. Each treatment programme was specific to the offence present; both sex offences included the Sex Offender Treatment Programme, and the GBH offence included the Controlling Anger and Learning to Manage It treatment programme that are used in real life to increase the ecological validity of the vignette. The three vignettes which had a diagnosis of schizophrenia had a paragraph which showed the age 'James' was diagnosed with schizophrenia, mentioned medication, and how the symptoms of the mental illness affect 'James'. The questionnaire which followed the vignette consisted of 40 questions, which comprised the Attitudes Towards Offenders Scale (ATOS) (35 items, see Appendix 3) and the Social Distance Scale (SDS) (5 items, see Appendix 4). The ATOS measured attitudes towards the offender in the vignette and is an adapted version of the Attitudes Towards Prisoners scale created by Melvin, Gramling and Gardner (1985). The statements used in the questionnaire remained the same, however each statement was made specific to the offender in the vignette. An example statement: 'Offenders like James are different from most people'. This questionnaire was chosen as it measures attitudes towards rehabilitation, scope for change, and general feelings towards offenders, which gives an idea of how punitive a persons' attitudes are. It has been used extensively throughout the literature and was also the basis for Hogue's (1993) Attitudes towards Sex Offenders scale (ATS), and has high test re-test reliability ( $r=0.82$ ).

The Social Distance scale was taken from Link, Cullen, Frank and Wozniak (1987) and measured the degree of personal closeness participant desired from the offender in the vignette. An example question being 'I would feel comfortable having someone like James as a neighbour'. The original scale in Link et al. (1987) comprised of 7 items, however two items were removed for this study as they already existed in the ATOS. This scale also had high test re-test reliability ( $r=0.92$ ). The 5-point response scale for both questionnaires ranged from 1 'Strongly agree' to 5 'Strongly disagree'. A high score on the ATOS indicated high punitive attitudes, and a low score indicated less punitive attitudes. A high score on the SDS indicated a high level of

desired social distance. The internal consistency of the scales used in the present study was calculated for the ATOS ( $\alpha=0.92$ ) and the SDS ( $\alpha=0.9$ ).

The participant information sheet (see Appendix 1) informed the participant on what they would experience when completing the study and how their data will be used, and relevant contact information was included. It was specifically emphasised that the content of the study may be sensitive to some people, and should it be, then participation was not recommended. A consent form was used to ensure participants understood the information sheet and their rights to withdraw from the study. The social media website 'Facebook' was used to advertise the study and recruit participants.

## **Procedure**

The study gained ethical approval from the Psychology Ethics Committee at the University of Portsmouth (see Appendix 1). The study took on average 15-20 minutes to complete, and participants could complete the questionnaire either on a laptop/desktop computer or on a smartphone. Once participants sent an email request to take part, they were sent an automated email which thanked them for expressing an interest in taking part and contained a one-time link which was valid for 60 days. Upon clicking the link, participants were presented with an information sheet and informed consent form to which they had the choice to proceed to the study or withdraw. If participants chose not to proceed they were automatically taken to the end of the study. They were then presented with a demographics page which asked for their gender, occupation, and which age bracket they fell into. If participants selected '17 and under' they were automatically withdrawn from the study due to ethical guidelines. Participants were then randomly allocated using a randomizing tool on 'Qualtrics' to one of the six vignettes and were instructed to take their time to read the description of 'James'. They were then taken to the questionnaire where they were instructed to answer the following questions based on the offender they had just read about, and encouraged to give their own opinion. After answering the questions participants were presented with the participant information sheet for a second time and given the opportunity



to print it should they need it for debriefing purposes, and were sent an automated email thanking them for their participation.

### **Coding and Analysis**

Data was extracted directly from the Qualtrics survey into SPSS for analysis. Relevant questions in the ATOS were reverse-scored. General linear model was applied to the data to perform a 3 (Crime vignette) x 2 (Mental illness vignette) MANOVA examining responses to ATOS and SDS. Univariate analysis was used to analyse significant main effects found in the data. Multiple comparisons were conducted using the Bonferroni method. Hypotheses were one-tailed, and each hypothesis is explained separately in relation to the data in the results section.

## Results:

A multivariate ANOVA was conducted to establish the effects of the mental health vignette and the type of crime vignette on responses to the Attitudes Towards Offenders scale and the Social Distance scale.

**Hypothesis 1: Sex offences will elicit significantly more punitive responses from the public than the non-sexual offence and the child sex offence will elicit a more punitive response than the rape offence regarding both attitudes to offenders and the desire for social distance**

As predicted, descriptive statistics (see Table 2) showed mean scores for attitudes to offenders to be most negative for child sexual abuse followed by the rape offence, followed by GBH. This pattern was also reflected in the social distance scores with the desire for social distance being greatest towards the child sex offender and the lowest towards the violent offender.

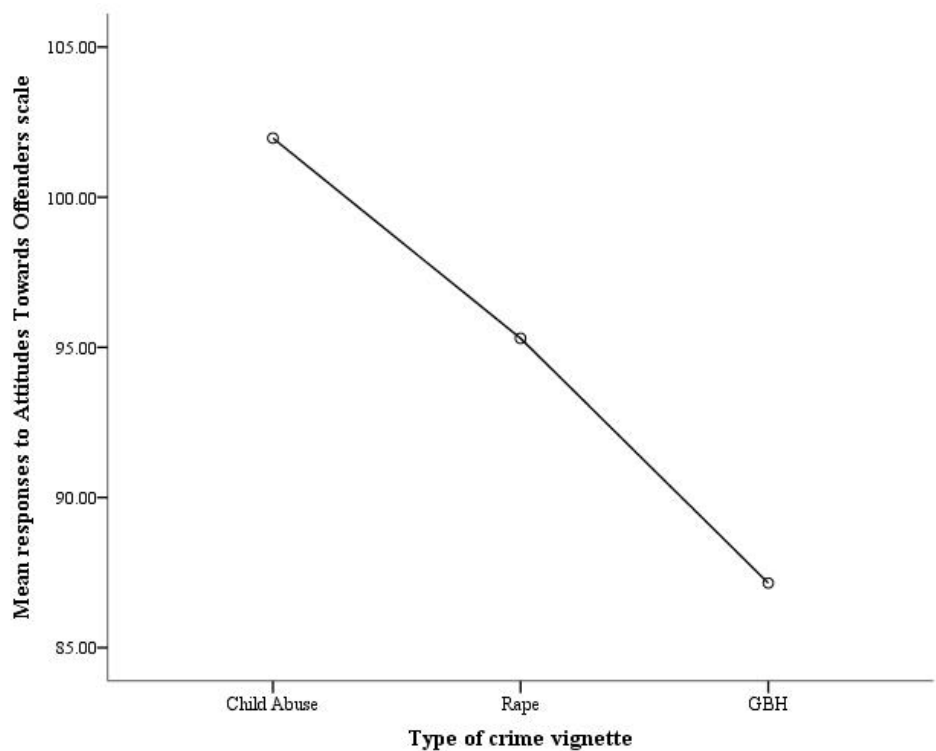
**Table 2**

**Differences in responses to attitudes and social distance according to type of crime vignette present ( $n=223$ )**

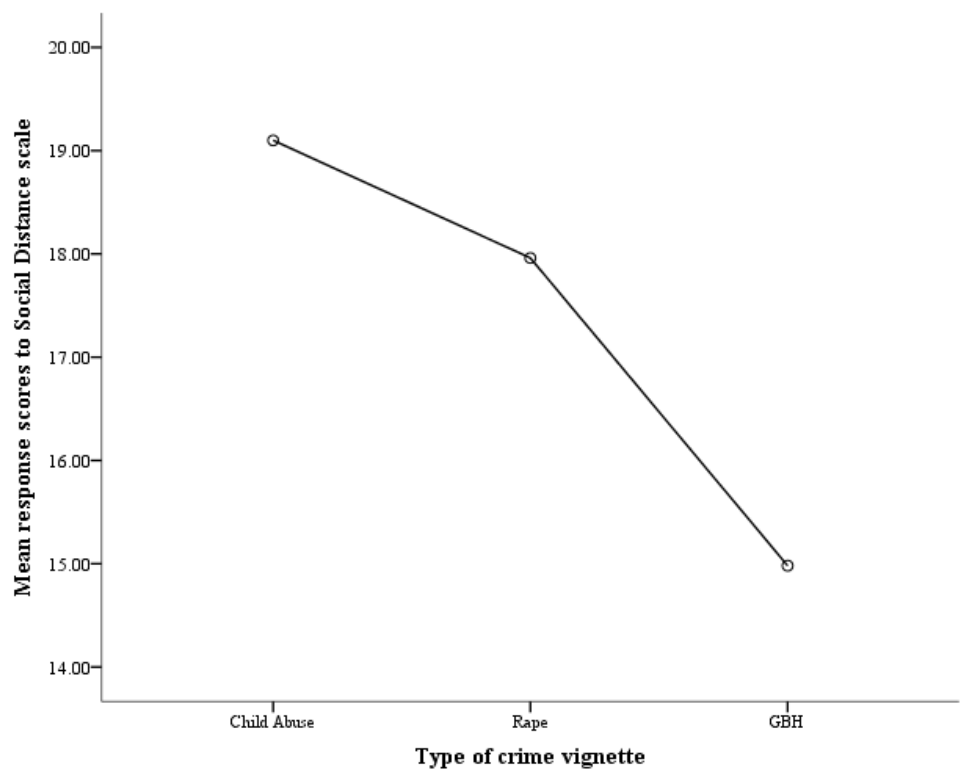
Type of crime vignette	Child sexual abuse ( $n=77$ )	Rape ( $n=76$ )	GBH ( $n=70$ )
	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )
<b>Total response scores on ATOS</b>	102.13 (17.6)	95.3 (15.06)	87.15 (13.36)
<b>Total response scores on SDS</b>	19.13 (4.25)	17.95 (3.88)	14.98 (3.32)

A significant main effect was found for type of crime  $F = (4,432) = 11.77$ ,  $p < .001$ , Wilk's  $\Lambda = 0.813$ ,  $\eta_p^2 = .098$ . Tests of between subject's effects indicated a significant effect for crime condition on attitudes to offenders  $F = (2,217) = 16.97$ ,  $p < .001$ ;  $\eta_p^2 = .135$  and social distance  $F = (2,217) = 22.47$ ,  $p < .001$ ;  $\eta_p^2 = .172$ . In relation to the crime condition and attitudes to offenders, pairwise comparisons indicated that each condition was significantly different from each other (see Fig 1, CSA and rape:  $p = .004$ ; CSA and GBH:  $p = .001$ ; rape and GBH:  $p = .001$ ). This meant that both sex offences elicited significantly higher negative responses than the non-sexual offence, the highest being the child sex offence.

A similar picture emerged for crime condition in relation to social distance, with pairwise comparisons showing each condition to be significantly different from each other (see Fig 2, CSA and rape:  $p = .036$ ; CSA and GBH:  $p = .001$ ; rape and GBH:  $p = .001$ ). This hypothesis is therefore supported.



**Figure 1. The effects of crime vignettes on responses to the Attitudes Towards Offenders scale**



## Figure 2. The effects of crime vignettes on responses to the Social Distance Scale

### Hypothesis 2: Mental illness will significantly reduce punitive attitudes towards offenders.

The effect for the mental health condition was approaching significance  $F=(2,216)=1.63$ ,  $p=.10$ ; Wilk's  $\Lambda=0.985$ ,  $\eta_p^2=.015$ . Table 3 shows mean scores for ATOS when schizophrenia was present were lower than the mean scores when schizophrenia was present and followed the trend hypothesised. However, as the main effect was not significant this hypothesis was not supported.

**Table 3**

**Mean scores for ATOS according to type of mental health vignette present**

Type of mental health vignette	Schizophrenia ( $n=109$ )	No Schizophrenia ( $n=114$ )
	$M$ ( $SD$ )	$M$ ( $SD$ )
Total response scores on ATOS	92.94 (1.45)	96.67 (1.45)

### Hypothesis 3: Mental illness would elicit significantly higher social distance scores for child sexual abuse than rape and GBH offences

A significant interaction effect was found for mental health vignette and type of crime  $F=(4,432)=2.07$ ,  $p=.04$ ; Wilk's  $\Lambda=0.963$ ,  $\eta_p^2=.019$ . Tests of between-subject's effects showed that the interaction between mental health and crime on the SDS was significant  $F=(2,217)=2.63$ ,  $p=.037$ ;  $\eta_p^2=.024$ , but not for the ATOS  $F=(2,217)=1.31$ ,  $p=.136$ ;  $\eta_p^2=.012$ . Mean scores for CSA (see Table 4) when schizophrenia was present were less than when schizophrenia was

not present and pairwise comparisons showed that the difference was statistically significant ( $p=.038$ ) indicating that having a mental illness significantly decreased desired social distance. Differences between scores for rape when schizophrenia was present and not present were not significant ( $p=0.128$ ), nor were they for GBH ( $p=.065$ ). This indicates that for CSA only, having a mental illness present in-fact produced significantly lower desire for social distance than when CSA was presented without a mental illness. Therefore, the hypothesis was not supported.

**Table 4**

**Responses to SDS for type of crime vignette according to the type of mental health vignette present**

Type of crime vignette	Child sexual abuse ( $n=77$ )	Rape ( $n=76$ )	GBH ( $n=70$ )
	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )
<b>Mean scores with Schizophrenia present</b>	18.32 (0.63)	18.46 (0.63)	14.29 (0.65)
<b>Mean scores when no Schizophrenia present</b>	19.88 (0.6)	17.46 (0.61)	15.68 (0.65)

### Sample norms

Further analysis was performed on the total scores for ATOS and total scores for SDS to compare to the norms found in previous research using the scales. Melvin et al. (1985) study used the Attitudes Towards Prisoners Scale to assess the public's attitudes towards inmates, an adapted version of the ATOS, and their total scores for their community sample ( $M=87.4$ ,  $SD=18.47$ ) were lower than the total scores found in this study ( $M=95.11$ ,  $SD=16.59$ ) and a one-sample t-test showed this to be significant,  $t(222) = 4.14$ ,  $p=.001$ . This

indicates that the sample in the present study produced significantly more punitive responses than in Melvin et al. (1985).

## **Discussion:**

The purpose of this study was to look at how the public respond to particularly stigmatized groups of offenders, and whether being aware that the offender suffers from a mental illness would affect responses. As predicted, findings showed that CSA elicited the most punitive attitudes from participants, followed by rape and GBH offences. Mental illness, however, showed not to have a significant effect on participants' attitudes; this did not support the prediction that mental illness would reduce punitive attitudes towards the offender. For social distance, predictions that CSA would elicit higher levels of desired social distance than rape and GBH were supported. In addition, mental illness only affected social distance with the child sexual offender; the offender with a conviction of CSA and no diagnosis of schizophrenia produced a higher level of social distance than when the diagnosis was present. These findings will be discussed in relation to previous research and theoretical explanations, and their implications for public policy and the re-integrating stigmatized offenders. The discussion will first look at implications for stigma and sexual offenders, and then turn to the impact of mental illness and social distance for such offenders.

### **Stigma and sexual offenders**

This research clearly shows that the public have varying attitudes towards different types of offenders, previously identified by McCorkle (1993). When comparing punitive attitudes to Melvin et al. (1985) it shows that the sample in this study were significantly harsher. This could imply that the public's views of offenders has got more punitive over time. However, it should be noted that the adaptation of the questionnaire in this study may have elicited harsher responses because they were being asked about a specific type of offender, whereas Melvin et al. (1985) looked at general attitudes towards prisoners.

In addition, this study is consistent with previous research showing the public have strong punitive attitudes towards sex offenders, with both the child sex



offence and the rape offence producing harsher responses than the violent offence. This supports the existing research on attitudes towards sex offenders, particularly the literature showing that the public's view of child sexual offenders is significantly harsher than other types of sex offences (Kernsmith et al., 2009; Rogers, Hirst & Davies, 2011). From this we can deduce that in relation to public attitudes, sex offenders are not a homogenous group, despite much of the research measuring attitudes towards sex offenders as one group using the Attitudes Towards Sex Offenders scale (ATS) (Brown, 1999; Ferguson & Ireland, 2006; Hogue, 1993; Nelson, Herlihy & Oescher, 2002). Nonetheless assessing attitudes towards different kinds of sex offenders seems beneficial to understand if a particular type of sex offender is more likely to become a victim of stigma, both in prison and on release.

It can be inferred from this study that the public have particularly negative attitudes towards child sex offenders, which could be explained using Corrigan and Watson's (2001) theory of public stigma; the endorsement of negative stereotypes associated with paedophiles and child sex offenders in turn produces prejudicial attitudes towards that vignette. It has been previously noted that there are negative stereotypes held about sex offenders which do not reflect empirical evidence (Sanghara & Wilson, 2006). Appearance and social status of the typical 'sex offender' is often assumed, as Sanghara and Wilson (2006) found that the less knowledge people had about CSA the more likely they were to endorse negative stereotypes, consistent with literature suggesting stereotypes are a cognitive shortcut for understanding groups of people (Hamilton & Sherman, 1996). Experience working with sex offenders also resulted in less stereotypical beliefs. This explanation could suggest why members of the public in the present study were so harsh, as negative stereotypes were activated resulting in prejudicial attitudes. Previous research shows this to have a detrimental effect on sex offenders' self-esteem and self-identity and can impact on their risk of recidivism (Trewskbury, 2011). Considering this it seems evident that efforts need to be made in reducing stereotypes about sex offenders, in particular

child sex offenders, to reduce the prejudicial attitudes, which prevent acceptance of those with a conviction of a sex offence.

It has been acknowledged that education on widely held stereotypes of sex offenders and increased contact between the public and this sub-group of particularly stigmatized offenders may reduce some of the discriminatory behaviour they face in society (Willis et al., 2010) as Nee and Witt (2013) also concluded in relation to offenders in general. Professionals who work closely with sex offenders in prisons and rehabilitation have shown to have more accepting attitudes compared to probation officers, police officers and teachers, implying that increased contact and education about these offenders may reduce stereotypical beliefs and stigma (Ferguson & Ireland, 2006; Viki, Fullerton, Raggett, Tatt & Wiltshire, 2012). Improvements have been made to the rehabilitation of sex offenders since the development of the Good Lives Model (GLM) (Ward & Steward, 2003) which, as well as addressing risks, focuses on the positive qualities of the individual and together the offender and the therapist attempt to find pro-social ways to solve basic human goals.

In addition, organizations such as Circles UK recognize the need for sex offenders to be accepted and work closely with the Ministry of Justice and probation services to support sex offenders on release from prison through weekly group meets, and has shown to have an 83% re-offending reduction amongst the sex offenders they work with (Circles UK, 2015). Yet if the same environment is not created by the public with whom the offenders must come into contact with to apply for jobs, housing and to build a lifestyle, this seems counterintuitive for rehabilitation. Thus, the offender is likely to become socially isolated and be withheld from achieving the goals worked towards in treatment and increase their risk of re-offending (Craig et al., 2005). This highlights the contradictions Brown (1999) found, showing the public are in favour of sex offender rehabilitation, yet their opinions on them being in the community are indirectly detrimental. The ultimate goal is to protect the public and prevent convicted sex offenders from re-offending, therefore society need to be aware that we also have a part to play in preventing this. The latter was re-enforced in a newspaper article where a convicted child sex offender

reported that after being released from prison he felt "rejected by the rest of society and so thrown back on the company of other sex offenders" as the only available accommodation for him being a hostel for released sex offenders (Stanford, 2015). Therefore, one possible step forward could be for the probation service to have more communication and involvement with landlords and employers, providing them with information and education on the risk that withholding life opportunities poses for the reintegration of sex offenders into society.

### **Stigma and mental illness**

It was found that mental illness did not affect participants' attitudes, and therefore did not support previous research suggesting that when the public are made aware of a mental health condition they are more lenient towards an offender (Nee & Witt, 2013). It could be said that if this study was repeated with a larger sample these results may have been replicated, as the results were approaching significance. However, an important point to take from this finding is that attitudes did not get more punitive due to the awareness of mental illness, therefore it could be implied that participants were accepting of the schizophrenia diagnosis and that did not affect their attitudes towards the offender they read about in the vignette. This has some positive implications for stigma and mental illness; the judgement of an offender is not affected by the fact they have a mental illness and could show that prejudicial attitudes previously found in research on stigma and mental illness may have improved (Angermeyer & Dietrich, 2006; Feldman & Crandall, 2007; Link et al., 1999). This finding also has implications for those sex offenders who suffer from mental illness, as found in previous research (Burk & Burkhart, 2003; Harsch et al., 2006; Leue et al., 2004). Harsch et al. (2006) interviewed and assessed sexual offenders in prison and in a psychiatric hospital and found a high prevalence of substance misuse and co-morbidity of Axis I and personality disorders. Both components are likely to make it even more difficult for the offender to adapt to life after imprisonment, as Dorkins and Adshead (2011) pointed out, therefore it is important that they are not victims of stigma due to

their mental illness and their offence. This research could suggest mental illness does not worsen the public's perception of sex offenders who also have mental illnesses.

### **Social distance**

This study also looked at the effect different types of offences would have on the amount of social distance that people would desire from the person depicted in the vignette. Results showed that people desired the most social distance from the child sexual offender, then rape; the GBH offender elicited the least amount of social distance. These results mirror the effect that offence type had on participants attitudes, suggesting that the more punitive they felt towards an offender the more social distance they desire. In this case, participants wanted the least personal contact with the child sex offender which supported existing literature showing child sex offenders to be the least desired offenders (Kernsmith et al., 2009; Smith, 1995). This could be explained by the NIMBY phenomenon proposed by Benzvy-Miller (1999), as participants may feel fearful that the offender would re-offend and endorse stereotypical beliefs. This is likely to be the case for members of the public with children, for fear that they would be in danger if the offender lived nearby. However, statistics show that the most common abuse against children is intra-familial; 8 in 10 children who are sexually abused know their abuser as a family member or family friend (Stop It Now!, 2003), contradicting widely held stereotypes about child sex offenders. In addition, the NIMBY phenomenon would assume that participants also dismissed the idea of having a child sexual offender in their area due to the tarnish it would bring to their neighbourhood. Yet, if all neighbourhoods exert such discriminatory behaviour then it seems there is no place in society where a child sex offender, who has been through rehabilitation, can be re-integrated and build the 'good life' which Ward and Stewart (2003) aim towards in their GLM.

Moreover, this study showed that the presence of a mental illness only affected social distance for the child sexual offender. Participants who read the vignette depicting a child sex offender, who also had a diagnosis of

schizophrenia received significantly less desire for social distance than the child sex offender without a diagnosis. This showed the opposite to predictions, implying that participants were more tolerant to personal contact with the child sex offender when they were made aware of a mental health problem. It is also interesting to note that mental illness only impacted on social distance with the child sex offender. The offender convicted of rape and GBH did not provoke differences in the levels of desired social distance with a mental illness present, which could have some positive implications for forensic psychiatric patients; previous research shows that having both attributes can make it significantly more difficult for the individual due to higher levels of social exclusion (Dorkins & Adshead, 2011).

However, for a child sex offender with no diagnosed mental illness and therefore not receiving psychiatric help, being even more so socially excluded is likely to propel them further towards re-offending, as Dorkins and Adshead (2011) states that 'madness gets therapeutic help but badness does not' (p.180). This finding is also similar to Nee and Witt's (2013) study showing that the individual with no mental illness, a disadvantaged background and criminal conviction is seen in the most negative light. It is perhaps that the public see the child sex offender with a mental illness as less to blame for their crime and therefore less likely to re-offend posing less threat to their society, the former identified by Weiner (1995) as an alternative reaction to people with mental illness, causing them to feel pity towards them.

Nonetheless, scores for both the convicted sex offenders were on the higher end of the SDS implying that social distance remains an obstacle for sex offenders. This has implications for education as a method for trying to reduce widely held stereotypes and stigma; it may improve knowledge about the group however this could cause them to be even less likely to want to have social contact. As previously noted by Willis et al. (2010), providing education programs for the public about sex offenders may have the opposite effect; studies on the impact of educational programmes designed to aide professionals working with sex offenders have shown that education does not improve their attitudes towards sex offenders (Craig, 2005). One limitation of this, however, is that professionals who work with sex offenders do generally

have more lenient attitudes towards sex offenders than the general public, which could account for there being no change in attitudes (Ferguson & Ireland, 2006; Viki et al., 2012). Taking this into consideration, it seems a useful step forward in reducing stigma and discrimination could be to have housing associations and employers more educated on the impact withholding life opportunities has on sex offenders and their risk of re-offending.

### **Limitations and future directions**

One limitation of attitudinal research is that it does not show the psychological process behind the participants' attitudes, and therefore explanations can only be assumed based on previous theory and research. Future research should refrain from assessing attitudes towards sex offenders as a homogenous group, and in addition research should look at the public's reasoning behind their attitudes, perhaps using a qualitative method. This would be beneficial for understanding what should be addressed in educational programs. It would also be useful to understand why the public view of offenders who have been convicted of rape less punitively, as this could have implications for survivors of rape and the issues they have reporting rape cases in the Criminal Justice System (Wilson & Scholes, 2009). This study was a good platform for empirically controlling levels of punitive attitudes towards different types of serious offences. Future research could build on these findings by including a wider range of offences such as acquisitive and petty crime to see whether these results remain consistent. A larger more stratified sample could be used to make the findings more generalisable to the public.

Using vignettes to elicit attitudes lacks ecological validity and does not necessarily represent the experience of coming into contact with a real life offender. It has been acknowledged that schizophrenia is not a typical mental illness amongst sex offenders (Alish et al., 2007), and therefore this may have limited the applicability of the vignettes to a real life sex offender. As this study used a non-sexual offender as a control, a mental illness that was well known to the public and applicable to other offenders was required in the vignettes.

In addition, the background of the offender was kept neutral which is not typical of a sexual offender, as many theories of child sexual offending suggest environmental factors during childhood contribute to sexually abusive behaviour (Marshall & Barbaree, 1990; Ward, Polaschek & Beech, 2006). An interesting direction for future research in this area could look at how the public respond to different types of sex offenders manipulating mental illness and disadvantaged background based on theories of sexual offending, making the vignettes more ecologically valid. This would provide further understanding of how the public feel towards sex offenders with a mental illness, based on findings in this study showing that awareness of a mental illness reduced social distance, which could be beneficial for education strategies. In addition, an offenders' background is something which research has shown can impact the public's perception of an offender (Nee & Witt, 2013).

To conclude, this study showed that both child sex offenders and rapists receive higher levels of punitive attitudes and desired social distance than a violent offender, which is nonetheless still a serious offence. However, it is difficult to say whether the stigma surrounding sexual offenders will change due to the emotional and sensitive nature of the crimes (Brown, 2009). There is evidence to show that over time stigmatizing attitudes can change and become more accepting, as recent research on stigma and mental illness has shown an improvement in stereotypical beliefs about people with mental illness (Schomerus et al., 2012). However, as promising as this is, the research also shows that social distance is a factor of stigma which remains an issue (Pescosolido et al., 2010). Future research should seek to understand why this is, for the benefit of the offender's re-integration and public protection in reducing the risk-factors associated with sexual re-offending.

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